N.C. Department of Health and Human Services

# Paying for Outcomes

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# What do North Carolinians want to pay for?

- Improved health status of the population
- Stabilization of individuals with chronic illnesses
- Prevention
- Best practices

# How can we achieve those goals?

- Incentive-based payments
- Value added services
- Bonuses
- Shared savings
- Non- financial incentives

# Incentive-Based Payment

- Goal: improve health care results through more efficient and higher quality of service delivery
- Reimbursement based on health outcomes
- Rewards/incentivizes health care plans and providers based on established benchmarks:
  - Quality outcomes
  - Efficiencies in service
  - Satisfaction among its members

# Incentive Based Payment

- Financial Models
  - Pay for Process
  - Bonus for achievement
  - Tiered bonus
  - Compensation at risk
  - Variable cost sharing
- Non-Financial Models
  - Performance profiling
  - Auto Assignment
  - Technical Assistance
  - Reduced administrative requirements

# Incentive-Based Payment

- Combined Models (Financial and Non Financial incentives)
  - Shared Savings
  - Complimentary Incentives

# Challenges

- Do incentive-based payments affect health care costs?
- Can one performance- based payment system control cost AND quality?
- How to measure savings? Control group, Trending, or baseline measure of cost?
- How large of performance incentive is necessary to affect provider behavior?
- How to measure effect of incentives:  Overall costs (entire benefit package like transplants) or targeted performance?
- Should states incentive-based payments with risk adjusted capitation?

# Conclusion

- NC pay for healthy outcomes
- More efficient delivery of care
- Increased access
- Motivate buy-in between provider and recipient

# Conclusion

- Unleash the power of the health care community to provide:
  - The right service
  - At the right location
  - To the right person
  - At the right price

# Inpatient Hospital Payments

- Claims payments
  - Inpatient
  - Outpatient
- Disproportionate share (DSH)
- GAP Plan supplemental payments

# Hospital Inpatient Claims

- Based on a Diagnostic Related Group Methodology (DRG) – where all diagnoses are grouped into 900 DRG's that represent the relative intensity of services provided
- Each DRG has an average length of stay, cost outlier threshold, and day outlier threshold
- Once the cost or day outlier threshold is exceeded, a cost or day outlier payment is made (but not both)

# Hospital Inpatient Claims

- Each hospital has an individual base rate that is used to calculate claims payments that is based on 1994 individual hospital cost
- Changes to base rate only occur in years when the Legislature approves an increase or decrease

# Hospital Outpatient Claims

- Non-laboratory claims, including emergency services, paid at 80% of the hospital's individual costs determined annually based on cost reports
- Claims paid based on an interim rate and then settled to 80% based on the cost report
- Laboratory claims paid on fee schedule

# Disproportionate Share Payments

- Federal allotment to each state to cover the impact of uncompensated care
- NC applies allotment in this order
  - State operated IMD's
  - UNC
  - Public hospitals
  - Private hospitals

# Disproportionate Share Payments

- State operated IMD's receive 33% of allotment
- UNC paid 100% of cost of uncompensated care
- $43 million retained by the state
- Remaining amounts reimburses hospitals for uncompensated care & supplemental payments
- IGT's used as state share for enhanced supplemental payments to QPH hospitals

# Hospital Gap Plan

- Approved in 2011, program to equalize hospital supplemental payments for inpatient and outpatient services
- Program supported by an assessment to all hospitals except UNC/Pitt and IMD's
- State retains $43 million of assessment

# Hospital Gap Plan

- Inpatient supplemental payments equal to Medicare payment rates less the Medicaid rate
- Outpatient supplemental payments equal to 100% of Medicaid costs less the claims payments based on 80% of cost

# Nursing Home Payments

- Nursing home rates reflect three elements – direct cost, indirect cost and facility costs (fair rental value)
- Rates based on 2005 cost for each facility
- Direct service rates adjusted quarterly for each facility's case mix

# Nursing Home Payments

- Direct and indirect base rates adjusted in years when the Legislature approves an increase or decrease
- Facility costs (fair rental value) adjusted annually based on a national survey of costs

# Questions?